

Health Information Technology Commission
Minutes

Date: Thursday March 21, 2013
1:00pm – 4:00pm

Location: MDCH
1st floor Capital View Bldg
Conference Room B&C
201 Townsend Street
Lansing, Michigan 48913

Commissioners Present:

Gregory Forzley M.D.-Chair
Toshiki Masaki – Vice Chair-Phone
Michael Chrissos-Phone
Nick Lyon
Orest Sowirka, D.O.
Irita Matthews
Mark Notman Ph.D.
Larry Wagenknecht R.Ph.
Michael Gardner
Jim Lee

Commissioners Absent:

Robert Milewski
Thomas Lauzon
David Behen

Staff:

Meghan Vanderstelt
Kimberly Bachelder

Guests:

Scott Larsen
Cynthia Green Edwards
Suzina Orelli
Elizabeth Hamilton
May Al Khafaj
Philip Vigas
Bruce Wiegand
Doug Dietzman
Jason Werner
Erin Bruder

Joe Abbott
Angela Vanker
Carol Parker
John Vismara
Katie Schaecher
Mimi Shaw
Umbrin Ateequi
Patty Houghton
Clare Tanner
David Tschirhart

Helen Hill
Tom Shewchuk
Paul Groll
Tim Pletcher
Jeff Livesay
Dana Green
Mark Gray
Hank Mayer

Minutes: The regular monthly meeting of the Michigan Health Information Technology Commission was held on Thursday March 21, 2013 at the Michigan Department of Community Health with ten Commissioners present.

A. Welcome & Introductions

1. Toshiki Masaki, Vice Chair started the meeting and welcomed the HITC members. Jim Lee, from the Michigan Hospital Association, was introduced as the newest HIT Commission member representing hospitals. Mr. Lee was

involved in the planning stages of the Michigan Health Information Network Shared Services (MiHIN) and has extensive experience in the health information technology field.

B. Review and Approval of February 21, 2013 meeting minutes

1. Minutes of the February 21, 2013 meeting were approved and will be posted to the HIT Commission (HITC) website following the meeting.

C. Dashboard

1. Vanderstelt reviewed the March 2013 Dashboard. A copy of the March dashboard will be available on the HITC website. According to the ONC National Dashboard, Michigan is ranked number one nationally for Total Directed Exchange and number two nationally for public health related messages being sent through an HIE. Tim Pletcher of MiHIN noted that the reason behind the high national rankings is due to all of the Qualified Organizations (QOs) reporting to ONC, pushing Michigan to the top.
2. Commissioner Comment: Commissioner Masaki inquired about formal national recognition regarding Michigan's elevated status. Vanderstelt stated that she received a congratulatory email for Michigan's accomplishments.

D. Cyber Security Follow Up

1. Scott Larson, Department of Technology Management and Budget (DTMB), and Jeff Livesay, (MiHIN) reported that the cyber security recommendations to the HITC were presented at the Governor's Cyber Security Task Force during the March 19, 2013 meeting. The Governor's Cyber Security Task Force had agreed to form a workgroup to examine the HITC Cyber Security recommendations in further detail and provide a more comprehensive report during May's meeting.
2. Commissioner Comment: Commissioner Lee inquired about how the cyber security recommendations that were presented to the HITC and the Governor's Task Force crosswalk with current HIPAA requirements. Livesay stated that HIPAA is a baseline for auditing requirements and the recommendations go beyond HIPAA requirements to ensure public trust. Larson added that the recommendations are based on the National Institute of Standards and Technology (NIST) security regulations, which is a requirement for all government systems. Commissioner Lee asked how medical devices were involved in the security discussion. Livesay answered that medical devices are a major concern, but currently are a difficult area to address. Commissioner Masaki asked what the HITC next steps should be. Commissioner Lyon (DCH) and Vanderstelt stated that the HITC will be able to respond after reviewing the recommendations from Governor's Cyber Security Workgroup during the next meeting. Commissioner Lyon of DCH, stated that he will be working in partnership with Commissioner Behen of DTMB.

E. 2012 Annual Report

1. Prior to the March HITC meeting, Vanderstelt sent out a revised draft of the 2012 Annual Report. This report included additional information on sub-state HIE activity that was requested at the last meeting.
2. Commissioner Comment: Commissioner Forzley suggested that next year's Annual Report include a map that illustrates HIE coverage and any gaps that may exist in Michigan. It was suggested that the map be broken down by county, which the Commission agreed upon. Commissioner Lyon asked that the 2013 Strategic Priorities be included in the 2012 Annual Report to assist with forecasting aligning HITC activities. The Commission unanimously agreed. With the one addition to the 2012 Annual Report, the Commission moved to accept and finalize the document. The HIT Commission approved.

F. Michigan Health Connect

1. Doug Dietzman, Executive Director, presented on behalf of the sub-state HIE Michigan Health Connect (MHC). MHC currently includes 65 hospitals, approximately 1,575 individual providers and 13 other member organizations within their sub-state umbrella. MHC is privately funded and does not impose charges to individual providers; hospitals are their primary financial supporters. Dietzman explained that MHC considers the organization an invisible entity in terms of data exchange and strives to complement existing technology, to focus on tangible problems within their market, to improve population health, and to do the best job they can in the absence of standards. MHC's current services include: Results Delivery, Lab and Radiology Orders, Physical and Behavioral Health Referrals, Virtual Integrated Patient Records (VIPR) which allows for query function, State Immunization Reporting (via MiHIN), State Reportable Labs (via MiHIN), Direct Health Internet Service Provider (HISP), and Admission/Discharge/Transfer (ADT) notifications (MHC Direct via MiHIN). Dietzman explained that MHC continues to look for new members, continues to add new solutions requested by clients, is collaborating with other sub-states HIEs (both internal and external to the State of Michigan), and would like to assist in the discovery of how HIE can continue to be used effectively.
2. Commissioner Comment: Commissioner Masaki noted his surprise on how few the numbers of staff MHC houses. Dietzman explained that their technology vendor, Medicity, is their technology resource, which allows for a smaller in-office staff. Commissioner Forzley inquired about recruitment efforts. Dietzman explained that the majority of their recruitment results from referrals from providers' partnerships with MHC affiliated hospitals. Commissioner Lee asked why ADT messaging was not an initial priority for MHC. Dietzman replied that initial demand was for lab and radiology results services. This formed the baseline use case and provided the first value add for MHC. As infrastructure has become more developed, ADT is now becoming more of a priority. Commissioner Wagenknecht inquired about the greatest barriers to the exchange of information. Dietzman answered that with the number of incentives and requirements associated with HIE, there is a high level of confusion among the provider community regarding the value

add of HIEs. Dietzman also explained there are many EMR vendors with different processes and technology platforms in the market, which slows down the connection process. Commissioner Mathews asked what the value proposition is for health plans to join an HIE, specifically MHC. Dietzman responded that health plans can quickly begin notifying associated providers to begin care, thus decreasing the days stayed in the hospital. Dietzman also suggested that health plans can hold affiliated providers accountable for receiving data electronically in order to eliminate phone and paper hassles. Commissioner Mathews also asked if it was possible for an organization to join multiple HIEs. Dietzman confirmed it was a possibility, but it tends to create more administrative burden for the organization who would be managing two different HIEs and being charged for similar services. Commissioner Notman asked what the biggest issues are for MHC. Dietzman explained that the HIE world and opportunities associated with it moves at a rapid pace. The challenge in the rapid environment lies with how to operate well and ignore sideline trails while managing growth. Commissioner Forzley inquired about measures that gauge MHC's success in providing benefits to participating providers. Dietzman noted that there is not much evidence at this time since initial needs focused on infrastructure and connection. In the future, they will start focusing on establishing baseline measures for evaluation. Commissioner Gardner asked which MHC HIE solutions are currently in high demand. Dietzman explained that Meaningful Use solutions such as immunization reporting and syndromic reporting are in demand, as well as Medication Therapy Management. New members tend to focus on establishing an interface and importing records. Commissioner Lyon asked what the patient's expectations for referrals are. Dietzman said the referral and patient records will be there waiting for the patient. The Community Viewer is currently in development (EMR or portal view). Commissioner Chrissos requested a timeline on the new MHC solutions being developed. Dietzman responded that current activities included: PACs, Medication Therapy Management (based on cost barriers), Care Transitions solutions (beta and roll out in summer), E med service network, and advanced care planning document solution (active this summer). The Commission asked what the State can do to assist providers with Medication History. Dietzman explained that MiHIN is taking a lead role in this area and conversations have already begun. Commissioner Lyon asked for an update on the agreement MHC had recently made with Priority Health. Dietzman explained that the current focus of the statement of work relates to ADT messaging.

G. Ingenium

1. John Vismara, Executive Director, presented on behalf of Ingenium. Vismara explained that their focus revolves around individual physicians and physician groups (first client was United Physicians Organizations). Vismara explained Ingenium's main goals include: leveraging shared infrastructure and data, focusing on physician access at the point of care, enabling change by empowering physicians, enabling population management and care coordination programs, and ensuring physical oversight and representation.

Vismara reported that Ingenium's technology platform consisted of a collaboration of AT &T and Covisint technology platforms; MPI, Clinical Data repository (CDR), Connectivity Hub, and Point of Care Access Points. Ingenium services consist of: immunization and Lab reporting (go-live is anticipated in early April via MiHIN), ADT pilot (via MiHIN), support query based sharing, point of care access to information, care coordination, and network based quality improvement programs, application access. Vismara reported that Ingenium's market strategy consists of growing steadily to minimize gaps in market (i.e. Specialist). Ingenium is also looking to grow by adding new physician networks, participating in a CMS Innovations grant, and developing new Health IT solutions including medication reconciliation tool and expanding Continuity of Care Document (CCD) sharing.

2. Commission Comment: Commissioner Masaki asked if revenue is based on membership or transactions. Vismara answered it is based on physician subscriptions. Commissioner Lyon asked for a further explanation of the CMS grant awarded. Vismara clarified that Altarum Institute is the main grantee. Ingenium is working with Altarum on developing and education on a CDR tool for radiology tests. Commissioner Lyon followed with a question about how the patient portal works. Vismara said that such a portal had been discussed for years, but Ingenium didn't want patient portal competition; they preferred to support existing portals, avoiding duplication and alienation of partner vendors. Mr. Vismara went on to explain that CCD sharing is done within the Ingenium network, and the Ingenium infrastructure is set up to do query-based exchange with other HIEs. Work continues with MiHIN to bring this query-based exchange to fruition, starting with physicians within the Ingenium umbrella. The Commission inquired about the largest barriers to HIE success for Ingenium. Vismara concurred with Dietzman (MHC) on provider confusion and EMR vendors. Commissioner Lyon inquired about Ingenium's goals in terms of use cases and State priorities. Vismara answered that Meaningful Use drives priorities and demand. For example immunization, ADT, and medication reconciliation are key areas.

H. Great Lakes Health Information Exchange

1. Carol Parker, Executive Director, presented on behalf of Great Lakes Health Information Exchange (GLHIE). Parker explained that GLHIE's focus is a community collaborative prioritizing patient health and safety as well as quality improvement. Current connections to GLHIE are: interfaces with EMR/EHR, Virtual Health Record (VHR) and Subscribe to Patient (query based exchange of data through GLHIE that allows providers to flow ADT information, medication, medical history, for a given patient). Current GLHIE use cases are connecting physicians and other health care providers electronically to facilitate clinical messaging and sharing encounter reports, results delivery, ADT notifications, query patient's community-wide longitudinal health record, subscribe to patient, and clinical messaging. Use cases in progress for GLHIE are care transitions, public health reporting, DIRECT, lab order gateway, radiology images, business analytics, IHE standards, facilitated communication between EMS providers and hospitals.

2. Commissioner Comment: Commissioner Lee asked whether DIRECT messaging is a threat to sub-state HIEs. Parker responded that DIRECT fills the ‘gray space’ that HIEs are unable to fill for either connectivity or security reasons. DIRECT complements HIE activity. Commissioner Matthews questioned how consumers will understand the protections of data sharing in GLHIE. Parker replied that security policies are described in GLHIE brochures, notifications, and other publications. Every provider in GLHIE has agreed to share and protect patient data and if they fail to do so, they risk being disconnected from the organization. Commissioner Forzley added that there are lots of audits to ensure confidence. Parker also said that most patients, when they find out about data sharing, react with something to the effect of “You weren’t doing this already?” Anecdotally, patients are in favor of sharing. Parker specified that sharing via DIRECT is provider-initiated. The provider makes a decision to send a secure message to another provider. GLHIE does give the option for providers within the organization to access information on patients they’re not normally associated with (“breaking the glass”) but they have to provide a very good reason for doing so. Commissioner Wagenknecht posed the question of what the greatest HIE barriers are for GLHIE. Ms. Parker mentioned the skyrocketing costs of EMR interfaces and bidirectional connectivity as being the major challenges. Commissioner Lee requested information regarding the ‘border region’ between MHC and GLHIE and the status of HIE to HIE connectivity. Ms. Parker replied that University of Michigan Health System and St. Joseph Trinity Hospital in Ann Arbor work with both MHC and GLHIE. Some tools used for multiple-HIE systems are different and require a lot of ad hoc sharing. The Subscribe to Patient tool with GLHIE sends information into the specific care management system. Commissioner Masaki wondered how a query from one HIE’s MPI to another worked, and where the gaps were within that process. Ms. Parker acknowledged that this was a tricky area, but the State of Michigan’s work through the MDCH Data Hub on the MPI synthesis issue was mentioned.

I. Public Comment

1. The next HIT Commission meeting was set for April 18, 2013.
2. No further public comment

J. Adjourn

1. Meeting Adjourned 3:34 p.m.